SB 1531-6
(LC 36)
2/9/16 (LHF/ps)

Requested by Senator BATES

PROPOSED AMENDMENTS TO
SENATE BILL 1531

On page 1 of the printed bill, line 2, after "411.404" delete the rest of the line.

In line 3, delete "414.652 and 414.653" and insert "and 414.652".

Delete lines 5 through 25 and delete pages 2 through 6 and insert:

"SECTION 1. Sections 2 and 4 of this 2016 Act are added to and made a part of ORS chapter 414.

"SECTION 2. (1) As used in this section:

"(a) 'Community benefit initiatives' means innovative programs or projects that benefit the health of the community, including but not limited to investments in health care management capabilities and increasing the capacity of the provider networks to serve the health care needs of the community.

"(b) 'Eligibility category' means the basis on which a member of a coordinated care organization qualifies for medical assistance.

"(c) 'Flexible services' means services that are provided in lieu of or as an adjunct to covered services.

"(d) 'Social determinants of health' means the conditions in which individuals are born, grow, live, work and age, including but not limited to food, safe housing, economic opportunities, health care, transportation and education.

"(2) The Oregon Health Authority shall determine the health ser-

vices to be provided by a coordinated care organization prior to establishing the global budget for the coordinated care organization. The determination shall be made no more than once every 12-month period, unless changes are required by federal law.

"(3) In establishing the global budget for a coordinated care organization for a calendar year, the authority shall take into account the coordinated care organization's costs incurred, expenditures and payments, other than fee-for-service payments, and reinvestment of savings into:

"(a) Providing health services; and

"(b) Providing flexible services, community benefit initiatives and other means of addressing the social determinants of health.

"(4) Not later than December 1, 2016, the authority shall establish data reporting requirements for coordinated care organizations that are uniform and sufficiently detailed to allow for comparisons of the data between coordinated care organizations. The data reported must include the sum of all payments made for each eligibility category and for each category of service including, but not limited to, aggregate payments for:

"(a) Inpatient hospital services;

"(b) Outpatient hospital services;

"(c) Emergency room services;

"(d) Physician and other professional services;

"(e) Dental care;

"(f) Laboratory and X-ray services;

"(g) Pharmacy services;

"(h) Durable medical equipment and supplies;

"(i) Vision care;

"(j) Substance use disorder treatment;

"(k) Mental health services other than substance use disorder

treatment;

"(L) Flexible services; and

"(m) Community benefit initiatives.

"(5) The authority shall make publicly available the data described in subsection (4) of this section except for data that would disclose payments made to an individual provider.

"(6) The authority shall provide to each coordinated care organization, no later than October 1 of each calendar year, the specific requirements and outcomes that the coordinated care organization must satisfy in order to qualify for incentive payments in the following calendar year.

"(7) Rules or policies adopted by the authority for the reporting of medical loss ratios must support the goals of the Oregon Integrated and Coordinated Health Care Delivery System including the use of alternative payment methodologies.

"SECTION 3. The Oregon Health Authority shall submit to the Centers for Medicare and Medicaid Services amendments to the state Medicaid plan or to this state's demonstration project as necessary to implement the provisions of section 2 of this 2016 Act on and after January 1, 2017.

"SECTION 4. (1) The Oregon Health Authority shall post to the authority's website, in a single, easily accessible location, all of the following:

"(a) The state plan for medical assistance submitted in accordance with 42 U.S.C. 1396a and any amendments to the state plan for medical assistance;

"(b) The terms and conditions of state demonstration projects under 42 U.S.C. 1315 and any amendments to the terms and conditions;

"(c) Waivers granted by the Centers for Medicare and Medicaid Services pursuant to 42 U.S.C. 1396n and any amendments to the

waivers; and

"(d) All official, written communications between the authority and the Centers for Medicare and Medicaid Services.

"(2) Official, written communications must be posted to the website no later than five days after the authority sends or receives the communication.

"SECTION 5. Upon the expiration of the five-year term of a contract between the Oregon Health Authority and a coordinated care organization, as defined in ORS 414.025, the authority shall offer to contract with the coordinated care organization for another five-year term unless the coordinated care organization:

"(1) Materially breached the terms of the contract;

"(2) Failed to comply with federal law governing the provision of medical assistance; or

"(3) Failed to make meaningful progress toward meeting the outcome and quality measures adopted by the authority under ORS 414.638.

"SECTION 6. ORS 414.652 is amended to read:

"414.652. (1) A contract entered into between the Oregon Health Authority and a coordinated care organization under ORS 414.625 (1):

"(a) May not contain terms that are inconsistent with state or federal law;

"(b) Must incorporate the provisions of this section and ORS 414.067 and 414.625 and section 2 of this 2016 Act;

"[*(a)*] **(c)** Shall be for a term of five years;

"[*(b)*] **(d)** Except as provided in subsection (3) of this section, may not be amended more than once in each 12-month period; and

"[*(c) May be terminated if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.*]

"[*(2) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures specified in the contract prior to the termination of the contract.*]

"(e) May be terminated if a coordinated care organization fails to meet outcome and quality measures adopted under ORS 414.638, substantially fails to meet criteria adopted by the authority under ORS 414.625 or is otherwise in breach of the contract.

"(2) The authority shall provide a coordinated care organization with a written notice and a reasonable amount of time in which to cure any failure to meet outcome and quality measures, or criteria adopted by the authority under ORS 414.625, prior to the termination of the contract or the authority's refusal to renew or to enter into a new contract with the coordinated care organization.

"(3) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

"(a) The authority and the coordinated care organization mutually agree to amend the contract; or

"(b) Amendments are necessitated by changes in federal or state law.

"(4) The authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts, or to contracts to be renewed, between the authority and the coordinated care organization.

"**(5) The authority may amend a contract with a coordinated care organization in order to adjust the global budget for the coordinated care organization during the following calendar year only if the authority:**

"(a) Has provided the coordinated care organization, not later than September 1, with an opportunity to review and respond to the amendments; and

"(b) Has submitted the amendments, not later than October 1, to the Centers for Medicare and Medicaid Services for review.

"(6) A global budget for a calendar year:

"(a) Must be established by the authority prospectively and may not be reduced retroactively;

"(b) May be reduced during a calendar year only in response to a decrease in the number of members enrolled in a coordinated care organization; and

"(c) May not be reduced for the following calendar year if the authority fails to comply with subsection (5) of this section.

"(7)(a) If a coordinated care organization, prior to agreeing to a contract term or proposed amendment to a contract with the authority, gives notice to the authority that the term or amendment conflicts with the provisions of this section or ORS 414.067 or 414.625 or section 2 of this 2016 Act, the coordinated care organization may file an action in circuit court to dispute the term or amendment. If the court finds that the term or amendment conflicts with the provisions of this section or ORS 414.067 or 414.625 or section 2 of this 2016 Act, the term or amendment shall be null and void retroactive to the date the coordinated care organization agreed to the term or amendment.

"(b) No later than 60 days after a coordinated care organization receives notice from the authority that the authority intends to amend a contract to reduce the coordinated care organization's global budget, the coordinated care organization may file an action in circuit court to dispute the proposed reduction based on the requirements of this section and section 2 of this 2016 Act.

"(c) An action described in this subsection may be filed in the Circuit Court for Marion County or the circuit court for the county in which the coordinated care organization has its principal place of business.

"(d) The authority may not terminate, refuse to renew or refuse to enter into a new contract with a coordinated care organization based upon the coordinated care organization's pursuit of its remedies under this subsection.

"SECTION 7. ORS 411.404 is amended to read:

"411.404. (1) The Department of Human Services or the Oregon Health Authority shall determine eligibility for medical assistance according to criteria prescribed by rule and in accordance with the requirements for securing federal financial participation in the costs of administering Titles XIX and XXI of the Social Security Act. **The department and the authority shall complete the determination of eligibility on all completed applications for medical assistance and renewals of medical assistance no later than 45 days, or 90 days if the determination is based upon an applicant's disability, after the applications are received by the department or the authority.**

"(2) Rules adopted under this section may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as the person's home.

"SECTION 8. (1) Section 2 of this 2016 Act and the amendments to ORS 411.404 and 414.652 by sections 6 and 7 of this 2016 Act become operative January 1, 2017.

"(2) Section 4 of this 2016 Act becomes operative 18 months after the effective date of this 2016 Act.

"SECTION 9. Section 5 of this 2016 Act is repealed on January 2, 2026.

"SECTION 10. This 2016 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect on its passage.".
